

Instructions for this Application Process

The focus of Children's Rehabilitative Services (CRS) is to improve the quality of life for children by providing family-centered medical treatment, rehabilitation, and related support services to enrolled individuals who have certain medical, handicapping, or potentially handicapping conditions.

To be eligible for services, the child or youth must:

- Be a U.S. Citizen
- Be an Arizona resident under 21 years of age
- Have an identified CRS physical disability, chronic illness, or medical condition that is potentially disabling

Anyone, including doctors, nurses, patients or friends may refer a child to CRS.

How to Apply

Step 1: Review Application Checklist and complete forms as instructed

If you need help completing the forms, call the Eligibility and Enrollment specialist at your nearest clinic or the statewide phone number below.

Step 2: Return Application and all required documentation to:

Mail: APIPA-CRS
Attn: Eligibility and Enrollment
PO Box 33320
Phoenix, AZ 85067-3320

OR

Fax: 1-866-623-1692

OR

Drop off at nearest clinic:

Clinic	Location	Phone Numbers
Flagstaff	1200 N. Beaver Street Flagstaff, AZ 86001	(928) 773-2054 1-800-232-1018
Phoenix	124 W Thomas Road Phoenix, AZ 85013	(602) 406-6400 1-800-392-2222
Tucson	2600 N. Wyatt Drive Tucson, AZ 85712	(520) 324-5437 1-800-231-8261
Yuma	2400 Avenue A Yuma, AZ 85364	(928) 336-7095 1-800-837-7309 Fax (928) 336-7497
Statewide		1-866-275-5776 TDD 1-800-367-8939

CRS REFERRAL/APPLICATION

CHILD'S NAME (Last, First, Middle)			RACE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH (mo/day/yr) / /
CHILD'S SOCIAL SECURITY NUMBER (if known)				PREFERRED LANGUAGE	ETHNICITY
PARENT OR GUARDIAN (Last Name, First Name)				RELATIONSHIP TO CHILD <input type="checkbox"/> Natural Parent (s) <input type="checkbox"/> Adoptive <input type="checkbox"/> Foster <input type="checkbox"/> Other	
CHILD'S ADDRESS	STREET	CITY	STATE	ZIP CODE	COUNTY
MAILING ADDRESS	STREET	CITY	STATE	ZIP CODE	US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No
HOME TELEPHONE () -	MESSAGE /CELL PHONE NUMBER () -		WORK PHONE NUMBER () -		E-MAIL ADDRESS
IN EMERGENCY NOTIFY (Name, Address, Phone)				RELATIONSHIP TO CHILD <input type="checkbox"/> Natural Parent (s) <input type="checkbox"/> Adoptive <input type="checkbox"/> Foster <input type="checkbox"/> Other	
CHILD'S Primary Care Practitioner ADDRESS PHONE NUMBER					
REFERRED BY: (Name, Address, Phone) (This individual verifies that the child's parent/guardian has been notified about this referral.)					
REASON FOR REFERRAL TO CRS:					
LIST PRIMARY DIAGNOSES (e.g., Cleft Lip, VSD, Cerebral Palsy, etc.) IF AVAILABLE, <u>PLEASE SEND MEDICAL RECORDS WITH THIS FORM.</u>					
1)		2)		3)	
4)		5)		6)	
LIST ANY KNOWN ALLERGIES					
1)		2)			
3)		4)			
HAS CHILD RECEIVED CRS SERVICES BEFORE? : <input type="checkbox"/> YES <input type="checkbox"/> NO YEAR? WHERE?					
NAME OF PERSON WHO COMPLETED THIS FORM ADDRESS PHONE () --					RELATIONSHIP TO PATIENT

ASSIGNMENT OF BENEFITS AGREEMENT/ CONSENT TO ENROLL

Does the child have Medical Insurance? ☐ YES ☐ NO

AHCCCS Health Plan ☐ NO ☐ YES If yes, AHCCCS ID # _____ AHCCCS Health Plan: _____

I agree that any moneys received by me as a court award or settlement of a claim which provides for medical care of the child shall be used to pay the Children's Rehabilitative Services (CRS) providers for care which is authorized and provided. I agree that when insurance benefits, court awards, claim settlements or other third party benefits are available, I shall make them available before CRS funds shall be used to provide care for the child or shall be used to reimburse CRS or the CRS contractor for all care provided to the child. If I receive and convert any benefits described by this subsection to my personal use and not for payment of the child's CRS services, I shall be personally responsible for the payment of the services for which the benefits were intended to pay.

I agree to provide all information necessary to enable CRS and CRS providers to collect such insurance. I agree to notify CRS within ten (10) days of any financial or insurance changes that would affect my financial eligibility.

If I lose Title XIX or Title XXI eligibility, I may be required to pay for the CRS services received.

AUTHORIZATION TO RELEASE INFORMATION

I authorize CRS to release information necessary for the completion of hospital, other providers, and medical insurance claims. I also authorize CRS to exchange information with the Department of Economic Security or the Arizona Health Care Cost Containment System (AHCCCS) and other insurance companies as necessary to determine financial eligibility.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize any insurance company with whom I have coverage, to make payment directly to the hospital, clinic, physician, or other CRS provider rendering service. I also agree to forward any insurance moneys, received for services rendered through CRS, to the provider of such service. I agree to send copies of all explanation of benefits received by me from my health insurance company to CRS or CRS providers.

I certify that I have read this agreement, received a copy, and am authorized to act for the member and as his or her parent to execute and accept the terms, conditions and authorizations set out above.


CONSENT TO ENROLL

I certify that I give my voluntary consent for _____ (Child's Name) to be enrolled in the CRS program.

Financially Responsible Person _____ Date _____

FOR APIPA-CRS USE ONLY

APPLICATION REVIEWED BY:		DATE	<input type="checkbox"/> Approved	
SPECIALTY CLINIC ASSIGNMENTS:				
<input type="checkbox"/> PEND- diagnostic tests	<input type="checkbox"/> PEND- waiting for medical documentation	<input type="checkbox"/> DENY- no medical documentation	<input type="checkbox"/> DENY-not medically eligible	<input type="checkbox"/> DENY – Other reason

	Signature and Other Insurance Information Form 1-C	
Applicant (Child) Name (Last, First, MI)	Child's Date of Birth (dd/mm/yy):	

Does the child have Medical Insurance? [] YES [] NO *If no, skip to signature. If yes, Please include copy of all insurance information and/or insurance card.*

Primary Insurance Information:

Insurance Policyholder's Name:		Policyholder's Date of Birth (dd/mm/yy):
Insurance Company:		Phone #:
Billing Address:		
Policy/Plan #:		ID Number:
Group Name/ Number:	Effective Date:	Coverage Type(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision
Cost of Insurance Premium per Month: \$		

Secondary Insurance Information:

Insurance Policyholder's Name:		Policyholder's Date of Birth (dd/mm/yy):
Insurance Company:		Phone #:
Billing Address:		
Policy/Plan #:		ID Number:
Group Name/ Number:	Effective Date:	Coverage Type(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision
Cost of Insurance Premium per Month: \$		

We need your signature to process your application.

HIPAA Authorization to Release Information:

I agree to the release of personal and financial information from this application, including supplemental forms and supporting information to AHCCCS or DES for the purpose of determining eligibility for AHCCCS Health Insurance, if applicable.

Statement of Truth: I swear under penalty of perjury that the statements made on this application and any other statements that I made (or will make) during the application process are true and correct to the best of my knowledge. Photocopies I have provided (or will provide) are the same as the original document. I have read and understand all of the declarations above.

Signature of applicant, responsible adult
or authorized representative

Date

Relationship
to child

Before you mail your forms, check this list!!

To speed up your application, have you included?

- ☐ Referral/Application - Form 1-A (required)
- ☐ Consent to Enroll - Form 1-B (required)
- ☐ Signature and Other Insurance Coverage - Form 1-C (required) – don't forget to sign the form!
- ☐ Medical records from your doctor to support the CRS condition
- ☐ Proof of AHCCCS enrollment, if applicable

No AHCCCS Health Plan? Continue on with the Financial Application (Form 2A)

Only complete if not enrolled in an AHCCCS Health Plan

Applicant (Child) Name (Last, First, MI):	Date of Birth:	Marital Status of Applicant:
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HOUSEHOLD INCOME

EARNED INCOME

Wage Earner Name	Date of Birth	Relationship to Child (father, mother, guardian, child age 18-21 other – list,)	Gross Annual Income	Employed full time? Y/N If no, # hours worked per month: _____	Employer's Name	Work Phone Number
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			

OTHER EARNED INCOME – if none, mark “X” in No column and mark “\$0” in Total Amount

DOES ANYONE IN HOUSEHOLD RECEIVE OR HAS ANYONE APPLIED FOR ANY OF THE FOLLOWING LIST BELOW? If so, complete information and include documentation with your application. 1. AZ Training Program 2. AZ Works! Program 3. Baby Sitting, Child Care Income, Housekeeper or Home Health Aides 4. Blood or Plasma Sales 5. Job Opportunity and Basic Skills Training (JOBS) 6. Rental Income 7. Summer Youth Employment and Training Program (SYETP) 8. Other:	YES	NO	NAME OF PERSON WHO RECIEVES MONEY	TOTAL AMOUNT	HOW OFTEN PAID (i.e. weekly, every other week, monthly, annually)
				\$	
				\$	
				\$	
				\$	
				\$	
				\$	
				\$	
				\$	

Household Members (Names & Ages):

Name	Age	Name	Age	Name	Age

Only complete if not enrolled in an AHCCCS Health Plan

UNEARNED INCOME – if none, mark “X” in No column and mark “\$0” in Total Amount

DOES ANYONE IN HOUSEHOLD RECEIVE OR HAS ANYONE APPLIED FOR ANY OF THE FOLLOWING LIST BELOW? If so, complete information and include documentation with your application.

1. Social Security Benefits (SSA)
2. Veteran's benefits (GI) or other military benefits
3. Railroad retirement or other retirement benefits
4. Unemployment Insurance (UI) benefits
5. Industrial Compensation, Worker's Compensation, other disability
6. Money gifts or loans from friends or relatives, exceeding \$500 in a year
7. Alimony, spousal maintenance
8. Child Support (Enter number of children _____)
9. Income from land lease or royalty for Indian Land
10. Income from rent or sale of land, building, etc.
11. Prizes, awards, lottery winnings (cash only)
12. Payment from insurance settlement for medical condition
13. Indian Gaming Profit Distribution or Bureau of Indian Affairs Assistance
14. AZ Assistance Payments (TANF, General Assistance, SSI)
15. Foster care payments for Kids Care (Title XIX) members
16. Strike Pay
17. Trust Fund
18. Other

YES	NO	NAME OF PERSON WHO RECIEVES MONEY	TOTAL AMOUNT	HOW OFTEN PAID (i.e. weekly, every other week, monthly, annually)
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	

DEDUCTIONS

	Type	Amount Paid	How often paid (e.g. weekly, every other week, monthly, annually)
Medical Expenses – if none, mark “\$0” in amount paid. Include all documentation with your application.			
<input type="checkbox"/>	Health Insurance Premiums, past 12 months	\$	
<input type="checkbox"/>	Paid medical/dental expenses, in past 12 months	\$	
<input type="checkbox"/>	Unpaid medical/dental expenses, in past 12 months	\$	

Only complete if not enrolled in an AHCCCS Health Plan

Dependent Care/Child Care – if none, mark “None” in first box

Name of Child/ Dependent	Date of Birth of Child/ Dependent	Name of person paying for care	Amount of Payment	How often paid (e.g. weekly, every other week, monthly, annually)
			\$	
			\$	
			\$	
			\$	
			\$	

SUPPORTING DOCUMENTATION

Please mail or fax the following documentation (if available) with this application so we can process your financial eligibility:

- ☐ Pay stubs for the last 30 days or a written statement from your employer confirming your income;
- ☐ If self-employed, Federal tax return or most recent financial statement signed and dated;
- ☐ Cancelled checks or court orders stating any unearned income;
- ☐ Documentation of any paid and unpaid medical expenses incurred during the 12 months before submitting this application;
- ☐ Any court order or settlement related to the applicant's CRS condition;
- ☐ Expenditures from the court award or settlement made for medical services;
- ☐ Cancelled checks or court orders for child support payments;
- ☐ Documentation for all current dependent care expenses;
- ☐ All other documentation requested in financial application

Completed By (Print Name)

Signature

Date

Is the child enrolled in an AHCCCS health plan? Then no need for this form!

Before you mail your forms, check this list!! Have you included?:

- ☐ Financial Application – Form 2A
- ☐ Documentation requested on the Financial Application
- ☐ Items below:

<p>Proof of Age: One of the following may be used as proof of age: (Check one and include documentation)</p> <ul style="list-style-type: none"> <input type="checkbox"/> A certified copy of a birth certificate <input type="checkbox"/> A naturalization certificate reflecting U.S. citizenship <input type="checkbox"/> A current or expired U.S. passport <input type="checkbox"/> A certificate of U.S. citizenship <input type="checkbox"/> Proof of AHCCCS Eligibility <p>Citizenship: One of the following may be used as proof of citizenship/qualified alien: (Check one and include documentation)</p> <ul style="list-style-type: none"> <input type="checkbox"/> A certified copy of a birth certificate <input type="checkbox"/> A naturalization certificate reflecting U.S. citizenship <input type="checkbox"/> A current or expired U.S. passport <input type="checkbox"/> A certificate of U.S. citizenship <input type="checkbox"/> A document that verifies the applicant's status as a qualified alien <input type="checkbox"/> Indication of AHCCCS eligibility (except Federal Emergency Assistance, which is undocumented individuals). 	<p>Residency: One of the following may be used as proof of residency: (Check one and include documentation)</p> <ul style="list-style-type: none"> <input type="checkbox"/> A rent or mortgage receipt for property located in Arizona <input type="checkbox"/> A lease for property located in Arizona <input type="checkbox"/> A written statement confirming residence at an Arizona nursing care institution <input type="checkbox"/> An unexpired Arizona motor vehicle operator's license <input type="checkbox"/> A current Arizona motor vehicle registration, issued within 12 months from the date of an application for enrollment in CRS <input type="checkbox"/> Recent pay stub from an Arizona employer (within the last 30 days) <input type="checkbox"/> A utility bill for property in Arizona <input type="checkbox"/> A current phone directory listing for a telephone located at property in Arizona <input type="checkbox"/> A United States Post Office record reflecting an Arizona residence <input type="checkbox"/> A certified copy of a school record reflecting an Arizona residence <input type="checkbox"/> A copy of religious record reflecting an Arizona residence <input type="checkbox"/> If none of the documents listed above are available, and the applicant resides in Arizona, the applicant, or of the applicant is a minor, the applicant's parent or legal guardian, may sign an affidavit certifying the individual is currently an Arizona resident and intends to remain in Arizona
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